Benefits Handbook Date September 1, 2010

Health Care Flexible Spending Account

MMC

Health Care Flexible Spending Account

The Health Care Flexible Spending Account Plan (the "Plan") allows you to put aside money before taxes are withheld so that you can pay for eligible medical, dental and vision expenses that are not reimbursed by any other coverage you and your qualifying family members have.

A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this one. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

SPD and Plan Document

This section provides a summary of the Health Care Flexible Spending Account Plan (the "Plan") as of January 1, 2010.

This section, together with the *Administrative Information* section and the applicable section about participation, forms the Summary Plan Description and plan document of the Plan.

Contents

The Plan at a Glance

Plan Feature	Highlights
How the Plan Works	▪ You may contribute to the Plan through payroll deductions on a before-tax basis. ▪ When you have reimbursable health care expenses, you can receive your money back tax-free, up to the amount you elect to contribute for the year. ▪ You are reimbursed for eligible expenses that are not covered under another benefit plan.
Eligibility	▪ You are eligible if you are an employee classified on payroll as a U.S. regular employee of MMC or any subsidiary or affiliate of MMC (other than Kroll, Inc., and any of its subsidiaries or Marsh & McLennan Agency, LLC and any of its subsidiaries (MMA)). ▪ You are eligible if you are classified on payroll as a U.S. full-time regular employee of Kroll, Inc. or any of its subsidiaries. ▪ You are eligible if you are an employee classified on payroll as a U.S. regular employee of MMA Corporate, the NIA Agency or the Brady & Company Agency. ▪ See "Participating in the Plan" on page 2 for details. ▪ The account can be used for your own eligible expenses and for expenses INCURRED to care for certain members of your family members (even if they are not participating in Company healthcare plans).
Enrollment	▪ You are eligible to enroll: – within 30 days of the date you become eligible – during Annual Enrollment ▪ You must enroll each PLAN YEAR in order to participate in the Health Care Flexible Spending Account. ▪ You are not eligible for this plan if you enroll in the MMC Health Savings Account.
Contributions	▪ You can contribute between $120 and $7,200 per Plan year.
Reimbursements	▪ In general, the Plan will reimburse expenses: – for your share of eligible health care costs for your care or for the care of qualified family members that are not paid for by your health plan, including copayments, deductibles, coinsurance and costs after your health plan paid a benefit, – that generally would be qualified medical expenses under federal tax law, and – that are for health care expenses incurred in the Plan year (including the GRACE PERIOD) for which you make contributions.

Plan Feature	Highlights
Unused Contributions	▪ If you have a balance remaining in your Health Care Flexible Spending Account after December 31 of the Plan year, you have a grace period until March 15 of the following Plan year to incur eligible expenses (provided you were still participating on December 31 of the Plan year and excluding expenses incurred after your employment ends). ▪ In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses incurred by March 15 of the following Plan year (the end of grace period) if they are not submitted by May 31.
Contact Information	For more information, contact: Aetna Flexible Spending Account (Claims Administrator) P.O. Box 4000 Richmond, KY 40476-4000 Phone: (888) 238-6226 Fax: (888) 238-3539 Website: www.aetna.com/docfind/custom/mmc MMC does not administer this plan. Aetna Flexible Spending Account's decisions are final and binding.

Participating in the Plan

You are eligible to participate in the Health Care Flexible Spending Account if you meet the eligibility requirements described in the *Participating in Spending Accounts* section.

If you are an eligible employee contributing to a health spending account, you can use that account to cover eligible health care expenses for family members who meet the eligibility requirements that are described in the *Participating in Spending Accounts* section.

You are not eligible for this plan if you enroll in the MMC Health Savings Account. In addition, you cannot be covered by any other health care flexible spending account (e.g., through your spouse's employer) if you contribute to a health savings account in the same calendar year.

You can enroll in this plan even if you are not enrolled in any Company health plan.

My spouse contributes to a health savings account (HSA); can I participate in the Health Care Flexible Spending Account?

If you choose to participate in the Health Care Flexible Spending Account, your spouse will not be eligible to contribute to a health savings account (HSA) under IRS rules.

My spouse contributes to a limited purpose health care flexible spending account; can I participate in the Health Care Flexible Spending Account?

No. If your spouse contributes to a limited purpose health care flexible spending account, you cannot participate in the Health Care Flexible Spending Account under IRS rules.

Enrollment

To participate in this plan, you must enroll for coverage. You may enroll:

- within 30 days of the date you become eligible to participate,
- during Annual Enrollment
- within 30 days of a qualifying change in family status that makes you eligible to enroll.
- You must enroll each PLAN YEAR in order to participate in the Health Care Flexible Spending Account.

Enrollment procedures are described in the *Participating in Spending Accounts* section.

Contributions

How do I decide how much to contribute?

You select an amount to contribute for the PLAN YEAR. You can contribute between $120 and $7,200 per Plan year.

Since you will forfeit any amount you do not use and you cannot change the contribution election once you make it (unless you have a qualified family status change), you should carefully estimate your expenses before deciding on an amount to contribute.

You have to contribute to the Plan to be reimbursed for eligible expenses you incur during the Plan year or during the GRACE PERIOD. You cannot be reimbursed for services that are provided before your coverage begins or after your coverage ends.

Once you make your selection for the year, you cannot make any changes, unless you have a qualified family status change and then any changes must be due to, and consistent with, the qualified family status change.

If your projected expenses change during the year, you will not be able to change your contribution election to meet your new expense amount unless you have a qualified family status change. For example, if your health care provider tells you during the year that you are no longer a candidate for the LASIK eye surgery for which you had been contributing to the Health Care Flexible Spending Account or is postponing a procedure to a subsequent year, you cannot reduce or stop your contributions.

Does the Company contribute to my spending account?

No, the Company does not make contributions to your account.

What is the minimum amount I can contribute?

You can contribute a minimum amount of $120 per Plan year to the Plan.

What is the maximum amount I can contribute?

You can contribute a maximum amount of $7,200 per Plan year to the Plan.

My spouse's or domestic partner's employer also has a spending account that my spouse or domestic partner contributes to; is there a limit to how much I can contribute to my spending account?

You and your spouse or domestic partner are each limited to the maximum contribution allowed by your respective employers. You can submit a claim only once and only to one spending account.

My spouse or domestic partner and I both work for the same company; how much can we put in the Plan?

You and your spouse or domestic partner can each contribute up to $7,200 per Plan year to this plan.

You cannot receive reimbursement for the same claim from both employees' accounts.

How are contributions credited to my account?

Your contributions will be deducted on a before-tax basis from each paycheck you receive after you commence participation and credited to your account.

When will contributions start to come out of my paycheck?

When you first enroll as a newly eligible employee or as a result of a qualified family status change, your contributions will begin in the next available pay cycle.

If you enroll during the Annual Enrollment period, your contributions will begin with the first paycheck of the new Plan year.

Can I transfer contributions between my Dependent Care and Health Care Flexible Spending Accounts?

No, the IRS requires that this Plan and the Dependent Care Flexible Spending Account remain separate. You cannot transfer money between accounts or use money in one account to pay expenses related to the other.

What happens to contributions in my spending account that I haven't used by the end of the grace period?

In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses INCURRED between January 1 and December 31 of the Plan year or between January 1 and March 15 of the following Plan year (the grace period) if they are not submitted by May 31.

If your participation ends during the Plan year, you will not be reimbursed for expenses incurred after the date your participation ends (for example, after your employment ends, unless you continue participation through COBRA). You will, however, have until May 31 of the following Plan year to submit for reimbursement eligible expenses you incurred during the Plan year while you were participating.

Taxes

See the *Participating in Spending Accounts* section for more information about taxes.

How the Plan Works

You may contribute to the Plan through payroll deductions on a before-tax basis. When you have reimbursable health care expenses, you can receive your money back tax-free, up to the amount you elect to contribute for the year. You are reimbursed for eligible expenses that are not covered under another benefit plan.

You contribute to the Health Care Flexible Spending Account over a 12-month PLAN YEAR, from January 1 to December 31 (or fewer months, if you start or stop participating during the Plan year). You may use your Health Care Flexible Spending Account to pay for eligible expenses INCURRED during the Plan year. If you have a balance remaining in your Health Care Flexible Spending Account after December 31 of the Plan year, you have an additional $2\frac{1}{2}$-month GRACE PERIOD (until March 15 of the following Plan year) to incur eligible expenses (provided you were still participating on December 31 of the Plan year and excluding expenses incurred after your employment ends). You then have until May 31 to submit for reimbursement eligible expenses you incur during the Plan year and during the grace period.

In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses incurred **by March 15 of the following** Plan year **(the end of** grace period**) if they are not submitted by May 31.**

Example: You can use your 2008 Health Care Flexible Spending Account to be reimbursed for eligible expenses incurred between January 1 and December 31, 2008 (the Plan year) or between January 1, 2009 and March 15, 2009 (the grace period). You must submit claims for those expenses no later than May 31, 2009.

Health care expenses described in IRS Publication 502 are examples for processing health care reimbursements. However, some items listed in this publication are not reimbursable under the Health Care Flexible Spending Account (e.g., premiums). Please check with the Claims Administrator if you have any questions about reimbursable expenses.

Reimbursements

In general, the Plan will reimburse expenses:

- for your share of eligible health care costs for your care and for care for qualified family members that are not paid for by your health plan, including copayments, deductibles, coinsurance and costs after your health plan paid a benefit,
- that generally would qualified medical expenses under federal tax law, and
- that are for health care expenses INCURRED in the PLAN YEAR (including the GRACE PERIOD) for which you make contributions

For examples of IRC Section 213 qualified medical expenses, see IRS Publication 502, which is available at www.irs.gov or by calling the IRS at 1-800-829-3676. Note that certain items listed in Publication 502 may not qualify for Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance. You may also contact the Claims Administrator, for information about reimbursable qualified medical expenses.

Who are the qualifying family members whose expenses may be reimbursed?

According to the IRS, a qualifying family member includes any person who qualifies for tax-free health plan benefits, including any of the following individuals:

- Your opposite-sex spouse
- A person for whom you can claim an exemption on your federal taxes
- A person who meets all of the following criteria:
  - Is your child (by birth or adoption), stepchild or foster child; your sibling or, step-sibling; or the descendant of your child, stepchild, foster child or sibling
  - Lives with you for more than half the year
  - Doesn't provide more than half his or her own support for the year
  - Is age 18 or younger for the entire calendar year; age 23 or younger and a full-time student for the entire calendar year; or permanently and totally disabled at any time during the calendar year (regardless of age)
  - Is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household
- Another person (e.g., relative, domestic partner, same-sex spouse) who meets all of the following criteria:
  - Receives more than half of his or her support from you during the calendar year

- Can't be claimed as anyone's "qualifying child" dependent
- Is your relative or, if the person is not your relative, he or she must live with you for the entire calendar year as a member of your household (except for temporary reasons such as vacation, military service or education) and the relationship cannot be in violation of local law
- Is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household

You can be reimbursed for eligible expenses for you, your spouse or your qualifying family members.

Unless your approved domestic partner or his or her children qualify for tax-free health plan benefits (as describe above), the federal government does not permit you to use health care flexible spending accounts for eligible expenses incurred by your approved domestic partner or his or her children.

How do I get Health Care Flexible Spending Account reimbursements?

You can be reimbursed from your Health Care Flexible Spending Account (FSA) Plan via direct deposit to your bank account or via a check.

The direct deposit payment is made via the "Streamline" feature of your Plan. Under the Streamline feature, all eligible expenses that were submitted but not paid under the CDHP (non-pharmacy), Exclusive Provider Organization Plan (EPO), Preferred Provider Organization (PPO) Plans, Pharmacy Plan or the Comprehensive Dental Plan are automatically deducted from your Health Care FSA and reimbursement is made directly to your bank account. You do not need to submit a paper claim form to be reimbursed.

If you enrolled in the Health Care FSA and you participate in the Consumer Directed Health Plan (CDHP) your out-of-pocket prescription drug expenses will be automatically deducted from your Health Care FSA and sent to the participating retail pharmacy. This occurs via the "AutoDebit" feature, a component of Streamline in which you were automatically enrolled.

Note: Aetna's Streamline feature is not available for the Vision Care Plan. You must submit a paper claim form to be reimbursed for eligible Vision Care Plan expenses.

To enroll in the Streamline feature contact Aetna Member Services at 1 (888) 238-6226 or access the Aetna Navigator™ member website at www.aetnanavigator.com, click on "Claims & Balances", then "Streamline Claims".

You must enroll, change or cancel direct deposit for your Health Care FSA by logging onto the Aetna Navigator™ member website at www.aetnanavigator.com. Click on "Claims & Balances", then "Direct Deposit" and complete the online form. Direct Deposit allows access to your funds sooner and saves time.

If do not want to enroll in the Streamline feature(s) then you must complete a FSA Health Care Reimbursement Form and return it as the form instructs in order to be reimbursed from your Health Care FSA account. Your reimbursement will be in the form of a check and sent to your address on file.

Unless your expenses are processed using automatic reimbursement, include:

- an itemized bill or statement
- an Explanation of Benefits detailing any reimbursement received from a benefit plan
- a copayment receipt

You should keep copies for your records.

Forms can be found on the Claims Administrator's website and on MMC PeopleLink. In the "Forms" section of MMC PeopleLink, click "View and Print Forms." Then, select "Dental/Medical/Flexible Spending Accounts" and click the "Aetna Health Care FSA Claim Form". You may also request a form from the Claims Administrator by calling 1 (888) 238-6226.

You should *not* participate in the Streamline Feature if:

- You have coordination of benefits through a non-Aetna Plan
- You have a domestic partner whose expenses are not FSA-eligible
- You do not want your reimbursements automatically processed for you via the Streamline feature

You can opt out of Streamline by contacting Member Services at 1 (888) 238-6226 or by accessing the Aetna Navigator™ member website at www.aetnanavigator.com, click on "Claims & Balances", then "Streamline claims".

Who issues the reimbursements?

Reimbursements are issued by the Claims Administrator. You can submit your eligible expenses for reimbursement at any time after you incur the expense.

Where can I get a Flexible Spending Account Health Care Reimbursement Form?

Forms can be found on the Claims Administrator's website and on MMC PeopleLink. In the "Forms" section of MMC PeopleLink, click "View and Print Forms." Then, select "Dental/Medical/Flexible Spending Accounts." Select the Aetna Health Care FSA Claim Form.

You may also request a form from the Claims Administrator by calling (888) 238-6226.

How is the reimbursement paid from my account?

The Claims Administrator will do one of the following:

- deposit your reimbursement amount directly into your checking or savings account on file with Payroll
- send your check to your home address if you do not have direct deposit of your paycheck

Your first reimbursement may be paid by check while the Claims Administrator authenticates your bank information for direct deposit.

How long does it take for claims to be processed?

Reimbursements are processed within five to seven days of the Claims Administrator's receipt of the completed claim form and required documentation.

Do I need a minimum amount of expenses before I can be reimbursed?

The minimum reimbursement is $25. You should wait until your eligible expenses total at least $25 before you submit them for reimbursement.

If your remaining eligible expenses incurred through March 15 of the following Plan year (that is, the end of the grace period) are less than $25, you can submit them and be reimbursed for eligible expenses.

How much can I be reimbursed?

The total amount elected for the Plan year is available for reimbursement at the start of the year, regardless of your contributions at the time of reimbursement.

What if the amount of my expense is more than I currently have in my account?

You will be reimbursed up to the annual amount you have elected to contribute. You do not have to wait until your account is sufficient to cover your expense.

Can I be reimbursed before I pay my provider?

Yes, you may request reimbursement for qualified medical expenses that are incurred during the Plan year before you pay for them. IRS rules say that expenses are incurred only after the service or item has been provided, not when you are formally billed or pay for the service.

If your item or service does not qualify for automatic reimbursement, you must submit documentation confirming that services were rendered including dates of service, services rendered and your cost for these services (such as an itemized statement from your provider or an Explanation of Benefits from the insurer) before you can be reimbursed for eligible expenses.

Can I be reimbursed for expenses incurred before participation in the Plan?

No, expenses incurred before your participation begins cannot be reimbursed.

How often can I request reimbursement?

You can submit your expenses for reimbursement as often as you would like after services have been provided to you, but the minimum reimbursement is $25.

In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses incurred before March 15 of the following Plan year, if they are not submitted by May 31.

What happens to contributions in my spending account that I have not used by the end of the grace period?

In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses incurred between January 1 and December 31 of the Plan year or between January 1 and March 15 of the following Plan year (the grace period) if they are not submitted by May 31.

If your participation ends during the year, you will not be reimbursed for expenses incurred after the date your participation ends (for example, after your employment ends, unless you continue participation through COBRA). You will, however, have until May 31 of the following Plan year to submit for reimbursement eligible expenses you incurred during the Plan year while you were participating.

How do I appeal a benefit determination or denied claim?

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

How can I get a copy of IRS Publication 502?

Go to www.irs.gov and enter “502" in the “Search” box for more information about IRC Section 213 qualified medical expenses. Note that certain items listed in Publication 502 may not qualify for Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance.

Please check with the Claims Administrator if you have any questions about reimbursable expenses.

Examples of Eligible Expenses

Expenses reimbursed by the Plan include:

- medical services provided by medical practitioners and that are not reimbursed by another medical plan

- charges for medically necessary services not reimbursed by medical and dental plans, including but not limited to the following:
  - deductibles
  - out-of-pocket expenses
  - copayments
  - coinsurance
  - charges exceeding reasonable and customary amounts
  - charges exceeding plan limits
  - prescription drug charges
  - other non-covered charges
  - all medically necessary prescription drugs and certain other prescription drugs permitted by the IRS (e.g., contraceptives and pre-natal vitamins)
  - certain over-the-counter non-prescription medicines, such as allergy and cold medications, aspirin and antacids, if they are intended to alleviate or treat personal injuries or sickness
  - eye exams, glasses (frames and lenses), contact lenses and solutions for contact lenses
  - dental implants
  - hearing exams, hearing aids
  - cost differences between semi-private and private hospital rooms
  - cost for special medical equipment installed in your home, or for home improvements for purposes of medical care, e.g., ramps, support bars, railings, etc.
  - fees for special schools on the recommendation of a physician, including schools for the mentally impaired, physically disabled or individuals with severe learning disabilities
  - transportation (amounts paid for travel primarily for, and essential to, medical care)
  - personal use items if primarily used to prevent or alleviate a physical or mental defect or illness, e.g., wigs, Braille books, hearing aids
  - nursing services in hospital, nursing home or your home

- smoking cessation programs
- weight loss programs (if you have a letter from your treating physician indicating medical necessity)
- alternative medicine
- Christian Science practitioners

For examples of IRC Section 213 qualified medical expenses, see IRS Publication 502, which is available at www.irs.gov or by calling the IRS at 1-800-829-3676. Note that certain items listed in Publication 502 may not qualify for Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance. You may also the Claims Administrator for information about qualified medical expenses.

Examples of Ineligible Expenses

You cannot be reimbursed for certain health care expenses, such as:

- contributions to other employer-sponsored medical or dental plans, including plans sponsored by your spouse's employer (contributions to the Company's health plans are already made on a before-tax basis)
- premiums made to any health care plan, including COBRA, Medicare, and plans sponsored by your spouse's employer
- costs you deduct as health care expenses on your federal income tax return
- expenses not eligible to be deducted under federal tax law
- expenses reimbursed by any other health plan
- health club membership dues
- cosmetic surgery, electrolysis, hair removal or transplants, liposuction, etc.
- vitamins and other dietary supplements, toiletries and cosmetics that are not medically necessary
- medications purchased merely to maintain your or your family's health
- prescription drugs that are not medically necessary and not permitted by the IRS (such as Rogaine)
- cosmetic dental work (including bleaching, bonding and veneers)
- undocumented travel to or from your physician's office or other medical facility
- weight loss programs (unless you have a letter from your treating physician indicating medical necessity)
- long-term care premiums and services

About Your Account

How can I find out my unused account balance?

To find out the balance in your account, log in to the Claims Administrator's website. If you are not currently registered, go to the Claims Administrator's website and follow the instructions for registration. Once you are registered, you will be able to login to the Claims Administrator's website and access your account information.

A statement showing your account activity will be issued twice per year in April and September and with each reimbursement check or direct deposit into your bank account.

What information can I find on my account statement?

You will find the following:

- the dates on which the reimbursements were made
- your balance as of the statement date
- your reimbursements
- your total contributions

Do I earn interest on my account?

No, your account does not earn interest.

Glossary

EXPLANATION OF BENEFITS

An Explanation of Benefits is a statement that the Claims Administrator sends to you after you, one of your covered family members or your health care provider files a claim for benefits. The Explanation of Benefits shows the charges that were submitted, the amount paid or not paid, and your balance, if any.

INCURRED

Expenses are treated as having been incurred when the care or service is provided, not when you are billed or pay for it.

PLAN YEAR

The Plan year is January 1 through December 31.

Grace Period

The grace period is the additional 2½-month period following the end of the Plan year. If you have a balance remaining in your Health Care Flexible Spending Account after the end of the Plan year and you are still participating on December 31 of the Plan year, you may use that balance to be reimbursed for eligible expenses incurred during the grace period. For example, if you do not use the balance in your 2008 Plan year Health Care Flexible Spending Account between January 1 and December 31, 2008, you may use the remaining balance to be reimbursed for eligible expenses incurred between January 1, 2009 and March 15, 2009 (the grace period).

Expenses incurred during the grace period but after your employment ends are not reimbursable.

Claims Filing Deadline

The claims filing deadline is May 31 following the end of the Plan year. For example, for the 2008 Plan year, your eligible expenses must be incurred no later than March 15, 2009 (the end of the grace period) and must be submitted to the Claims Administrator by May 31, 2009 (the claims filing deadline).